DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

National Institutes of Health

National Institute of Dental and Craniofacial Research

National Advisory Dental and Craniofacial Research Council

Summary Minutes

Date: September 21-22, 2000
Place: Building 31, Conference Room 6
National Institutes of Health
Bethesda, Maryland 20892

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

MINUTES OF THE
NATIONAL ADVISORY DENTAL AND CRANIOFACIAL RESEARCH COUNCIL

September 21-22, 2000

The 162nd meeting of the National Advisory Dental and Craniofacial Research Council (NADCRC) was convened on September 21, 2000, at 8:29 a.m., in Building 31, Conference Room 6, National Institutes of Health (NIH), Bethesda, Maryland. The meeting was open to the public from 8:29 a.m. to 4:52 p.m. on September 22, 2000, followed by the closed session for consideration of grant applications from 9:00 a.m. on September 22 until adjournment at 12:30 p.m. Dr. Lawrence A. Tabak presided as Chair.

Members Present:

Dr. John F. Alderete
Dr. Ernesto Canalis
Dr. Marilyn Carlson
Dr. D. Walter Cohen
Dr. Dominick P. De Paola
Dr. Samuel F. Dworkin
Dr. Jay Alan Gershen
Dr. Marjorie K. Jeffcoat
Dr. Harold Morris
Dr. Leslie A. Raulin
Dr. Joan Y. Reede
Dr. E. Dianne Rekow
Ms. Kim S. Uhrich
Dr. Everett Vokes

Members of the Public Present:

Mr. Adwan K. Boahene, *The Blue Sheet*, Chevy Chase, MD
Dr. Robert S. Bolan, Interim President and CEO, American Dental Trade Association, Alexandria, VA
Dr. Hillary Brode, University of Medicine and Dentistry of New Jersey (UMDNJ)- New Jersey Dental School, Newark
Ms. Valerie Carlson, American Dental Hygienists' Association, Washington, D.C.
Dr. Richard Carr, American Dental Education Association (ADEA), Washington, D.C.
Dr. Aida A. Chohayeb, Professor, Howard University, Washington, D.C.
Dr. Robert Collins, Deputy Executive Director, American Association for Dental Research, Alexandria, VA.
Dr. Jim Crall, Columbia University, New York, New York
Ms. Linda Hay Crawford, Division of Government and Institutional Relations, ADEA, Washington, D.C.
Dr. Cecile Feldman, UMDNJ-New Jersey Dental School, Newark
Dr. Karl Haden, Division of Educational Policy and Research, ADEA, Washington, D.C.
Dr. Preston Littleton, Jr., Education Director, International Federation of Dental Education Association, Potomac, MD
Ms. Gina G. Luke, Division of Government and Institutional Relations, ADEA, Washington, D.C.
Dr. Jonathan McLeod, Manager of Legislative and Regulatory Policy, American Dental Association, Washington, D.C.
Dr. Anthony Neely, Professor, University of Detroit, MI
Dr. Gordon Rovelstad, Director Emeritus, American Council of Dentistry, Shady Grove, MD
Dr. Eli Schwarz, Executive Director, American Association for Dental Research and International Association for Dental Research, Alexandria, VA

Dr. Jeanne C. Sinkford, Associate Executive Director for Equity and Diversity, ADEA, Washington, D.C.
Dr. Norman Tinanoff, University of Maryland, Baltimore, and Harold Löe Scholar

Federal Employees Present:

National Institute of Dental and Craniofacial Research:

Ms. Margo Adesanya, Staff Scientist, Craniofacial Epidemiology and Genetics Branch (CEGB), Office of Science Policy and Analysis (OSPA)
Ms. Carolyn Baum, Committee Management Specialist and Council Secretary,
Dr. David Barmes, Special Expert, Office of International Health (OIH)
Ms. Carol M. Beasley, Chief, Human Resources Management Branch, Office of Administrative Management (OAM)
Dr. Henning Birkedal-Hansen, Scientific Director, NIDCR, and Director, Division of Intramural Research (DIR)
Ms. Karina Boehm, Chief, Health Promotion Branch, Office of Communications and Health Education (OCHE)
Dr. Norman S. Braveman, Associate Director, Office of Clinical, Behavioral, and Health Promotion Research, Division of Extramural Research (DER)
Dr. Patricia S. Bryant, Health Scientist Administrator, Behavioral and Health Promotion Research, DER
Ms. Sharrell S. Butler, Diversity Program Manager, Office of the Director (OD)
Dr. Lois K. Cohen, Associate Director for International Health, and Director, OIH
Mr. George J. Coy, Chief, Financial Management Branch, OAM
Ms. Mary Daum, Writer, Public Information and Liaison Branch (PILB), OCHE
Dr. Scott Diehl, Senior Investigator, CEGB, DIR
Ms. Jody Dove, Public Information Specialist, PILB, OCHE
Ms. Yvonne H.du Buy, Associate Director for Management, and Director, OAM
Ms. Judith Dulovich, Personnel Specialist, OD
Ms. Brenda Farmer, Program Assistant, OIH
Mr. William A. Foley, Grants Clerk, Grants Management Branch (GMB), DER
Ms. Karen Fowler, Public Affairs Specialist, Health Promotion Branch, OCHE
Ms. Harriett Ganson, Planning and Evaluation Officer, OSPA
Dr. Isabel Garcia, Special Assistant for Science Transfer, OCHE
Ms. Christen Gibbons, Computer Specialist, Information Technology and Analysis Branch, OCHE
Dr. Carolyn Gray, Consultant
Dr. Kenneth A. Gruber, Chief, Chronic Diseases Branch, DER
Ms. Denise Halley, GTA, DER
Dr. Kevin Hardwick, International Health Officer, OIH
Dr. H. George Hausch, Chief, Scientific Review Branch (SRB), DER
Ms. Deane K. Hill, Computer Programmer, Planning, Evaluation, and Legislation Branch, OSPA
Ms. Lorrayne Jackson, Diversity Programs Specialist, and Co-Director, Diversity Programs, DER
Dr. Bernard W. Janicki, Special Assistant for Planning, Technology Transfer, and Management, DER
Ms. Susan M. Johnson, Chief, PILB, OCHE
Ms. Mary Kelly, Program Assistant, PILB, OCHE
Dr. Dushanka V. Kleinman, Deputy Director, NIDCR, and Executive Secretary, NADCRC
Dr. Eleni Kousvelari, Chief, Biomaterials, Biomimetics, and Tissue Engineering Branch, DER
Ms. Wendy A. Liffers, Director, OSPA
Dr. James A. Lipton, Assistant Director, Office of Training and Career Development, DER
Dr. Yujing Liu, Scientific Review Administrator, DER
Dr. Jack London, Special Assistant to the Director, DIR
Dr. Dennis F. Mangan, Chief, Infectious Diseases and Immunity Branch, DER
Dr. J. Ricardo Martinez, Director, DER
Dr. Robert Mecklenburg, NCI, Bethesda, MD
Dr. Maryann Redford, Health Scientist Administrator, Office of Clinical, Behavioral, and Health Promotion Research, DER
Dr. Edward Rossomando, Technology Transfer Program Director, OD
Dr. Martin Rubinstein, Chief, GMB, DER
Dr. Denise Russo, Program Administrator, AIDS Program, Infectious Diseases and Immunity Branch, DER

Dr. Ann L. Sandberg, Chief, Neoplastic Diseases Branch, and Director, Comprehensive Centers of Discovery Program, DER
Dr. Robert O. Selwitz, Senior Dental Epidemiologist, Health Promotion Branch, OCHE
Dr. Yasaman Shirazi, Scientific Review Administrator, DER
Dr. Judy A. Small, Chief, Craniofacial Anomalies and Injuries Branch, DER
Dr. Rochelle Small, Craniofacial Anomalies and Injuries Branch, DER
Ms. Cheryl Stevens, Special Assistant for Operations, OD
Dr. Philip Washko, Scientific Review Administrator, DER
Ms. Dolores A. Wells, Program Analyst, OD
Ms. Mary Ann Williamson, Computer Specialist, OIT, OD

Other Federal Employees:

Dr. C. R. Buchanan, Deputy Director for Dentistry, Department of Veterans Affairs, Washington, D.C.
Dr. Priscilla Chen, Center for Scientific Review (CSR), NIH
Dr. Felicia L. Collins, Clinical Coordinator, Office of Data Evaluation, Analysis, and Research, Bureau of Primary Health Care, Health Resources and Services Administration (HRSA), Rockville, MD
Dr. Bruce Dye, National Center for Health Statistics
Dr. J. Terrell Hoffeld, CSR, NIH
Dr. Lee P. Joseph, Food and Drug Adminstration, Rockville, MD
Cpt. Gary Kaplovitz, Dental Officer, U.S. Coast Guard
Dr. Ruth L. Kirschstein, Principal Deputy Director, NIH
Dr. Yvonne Maddox, Acting Deputy Director, NIH
Dr. Dolores Malvitz, Division of Oral Health, Centers for Disease Control and Prevention
Dr. Wendy Mouradian, Consultant
Dr. Jim Sutherland, Oral Health Coordinator and Regional Dental Consultant for the West Central Cluster, HRSA, Denver, CO
Dr. Sue Wheaton, Administration on Aging, Washington, D.C.
Dr. Jeannine Willis, HRSA, Rockville, MD
Dr. Randy Wykoff, Deputy Assistant Secretary for Health for Disease Prevention and Health Promotion, DHHS, Washington, D.C.

OPEN PORTION OF THE MEETING

I. CALL TO ORDER

Dr. Dushanka V. Kleinman, Deputy Director, NIDCR, called the meeting to order, welcoming all attendees to the 162nd meeting of the Council. For the second time, the Council meeting was televised to the broader research community on simultaneous NIDCR WebCast. Dr. Kleinman invited all the participants to introduce themselves.

She noted that the terms of three Council members are ending: Drs. Ernesto Canalis, Dominick P. De Paolo, and Marjorie K. Jeffcoat. Dr. Kleinman expressed NIDCR's appreciation to the members for their contributions to the Council and presented each with a small gift.

II. INTRODUCTION OF THE NIDCR DIRECTOR

Dr. Kleinman welcomed and introduced Dr. Ruth L. Kirschstein, Principal Deputy Director, NIH. Dr. Kirschstein formally welcomed and presented Dr. Lawrence A. Tabak as the next Director of the NIDCR. Dr. Tabak succeeds Dr. Harold C. Slavkin who departed the NIDCR on July 1 to return to the University of Southern California, Los Angeles, and to serve as dean of the School of Dentistry. Dr. Kirschstein noted that the NIH search committee for the new NIDCR Director was delighted with the caliber of candidates who applied for the position and with the appointment of Dr. Tabak, who was recommended by the committee as its first choice. Dr.

Tabak became the seventh Director of NIDCR effective September 1, 2000. The Council members welcomed and applauded Dr. Tabak.

Dr. D. Walter Cohen noted that the Friends of the NIDCR look forward to welcoming Dr. Tabak at its 2000 Gala Annual Awards Dinner, on October 23. He invited Council members and others to attend. The 2000 honorees include U.S. Surgeon General David Satcher, for lifetime achievement; Timothy Shriver, for public advocacy; Jane Brody, for excellence in the media; and Janet Crockett, the first recipient of the DENTSPLY Harold Slavkin Oral Health Science Education Award.

III. WELCOMING REMARKS AND REPORT OF THE DIRECTOR

Dr. Tabak thanked Dr. Kirschstein for her assistance during the transition and said that serving as the Director of NIDCR is a great privilege. He thanked the many persons within the NIH who have helped over the past few weeks, especially NIDCR's Executive Staff. He asked the Council to applaud Dr. Kleinman in particular for her support, guidance, and patience during the transition. On behalf of the NIDCR, he expressed appreciation for the efficiency of the search process, the support of the extramural community, and the past efforts and continuing involvement of the Council.

Dr. Tabak noted that he places high value on collaboration and involvement of all groups, practitioners, researchers, academicians, and the public and voluntary groups in the research and science transfer process. He was able to participate recently in NIH's annual Leadership Forum, meeting with other directors of the institutes and centers to address trans-NIH goals and operations. Dr. Tabak said that he has begun to meet with each director separately to address NIH's cross-cutting programs and their relevance to NIDCR and oral health research.

Dr. Tabak noted that the impending change in the Administration provides an opportunity to assess research accomplishments and identify gaps in understanding. He said that the NIDCR will enhance assessment and evaluation of its research and training programs, and he invited the Council's input on how best to use these tools for setting priorities. Dr. Tabak also noted that he will examine closely ways to enhance NIDCR's interface with the extramural community to ensure support for the best science possible and that he has already begun discussions with NIDCR's Scientific Director on ways to increase interactions between the intramural and extramural communities.

Dr. Tabak remarked that the recently published Surgeon General's report, Oral Health in America, presents a special challenge to redress the health needs of individuals most in need and that this effort coincides with the NIH-wide initiative on health disparities. Reflecting these emphases, the present meeting of the Council is devoted to the theme, "Health Disparities: How Can We Make A Difference?"

IV. APPROVAL OF MINUTES

The minutes of the Council's meeting on June 8-9, 2000, were considered and unanimously approved.

V. FUTURE COUNCIL MEETING DATES

The following dates for future Council meetings were confirmed:

January 22-23, 2001
June 12-13, 2001
September 24-25, 2001

January 28-29, 2002
June 10-11, 2002
September 26-27, 2002

VI. NIH PLAN FOR HEALTH DISPARITIES

Dr. Yvonne Maddox, Acting Deputy Director, NIH, described NIH's plan to address, and ultimately eliminate, health disparities. The NIH strategic plan, entitled "Addressing Health Disparities: The NIH Program of Action," reflects the emphases and priorities in strategic plans developed by each NIH institute. Dr. Maddox noted that health disparities have been an important issue for the NIH previously, as evident from the support for minority health research, which amounted to approximately $1.3 billion in Fiscal Year (FY) 1999. In the new, focused effort, the NIH is directly and aggressively addressing health disparities as a trans-NIH initiative.

This initiative was stimulated by President Clinton's commitment to eliminate disparities in health for racial and ethnic minority populations by 2010. For the U.S. Department of Health and Human Services (DHHS), this goal will parallel the focus of Healthy People 2010. Six priority areas have been identified. They are infant mortality, cancer screening and management, cardiovascular disease, diabetes, human immunodeficiency virus (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS), and immunizations. Dr. Maddox co-chaired the DHHS working group on infant mortality, and other NIH senior staff chaired other groups.

To organize the trans-NIH initiative, Dr. Harold Varmus, former Director, NIH, established a trans-NIH Working Group on Health Disparities in September 1999. Dr. Maddox noted that former NIDCR Director Dr. Slavkin chaired this initial group and that NIDCR staff essentially served as an executive secretariat. In January 2000, Dr. Kirschstein recharged the group to broaden its activities to include the directors of all NIH institutes and centers and to align preparation of the NIH Strategic Plan on Health Disparities with formulation of the FY 2002 budget. Dr. Maddox and Dr. Anthony Fauci, Director, National Institute of Allergy and Infectious Diseases, NIH, co-chair the current group. The draft strategic plan has just been completed and will be posted shortly on the web site for "NIH's Program to Address Health Disparities [http://healthdisparities.nih.
gov]." The plans of the institutes and centers are posted here as well. Dr. Maddox invited public comment on these plans.

For NIH's initiative, health disparities are defined as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." Socioeconomic status also is included as an important dimension. The NIH is focusing specifically on African Americans, Asians, Pacific Islanders, Hispanics and Latinos, Native Americans, and Native Alaskans.

Commenting on the health disparities among these groups, Dr. Maddox noted that the United States ranks 26th among developed countries in infant mortality and that the rate for African Americans is about two times the national average. Oral cancer is the fourth common cause of cancer among African American males and, compared to the white, non-Hispanic population, the incidence of, and mortality from, prostate cancer is much higher among African American males; mortality from breast cancer is slightly higher, although incidence is lower; the incidence of HIV/AIDS is much higher among Hispanics and African Americans; and incidence and mortality rates (e.g., for alcoholism, suicide, homicide, cervical cancer) among Native Americans and Alaskan Natives are abysmal.

As a research organization, the NIH is focusing its strategic plan on research to address the diseases and conditions associated with disparities. The working group developed recommendations in three areas: research, research infrastructure development, and community outreach. Within the broad master plan, the NIH also will expand recruitment of minority participants into clinical research and clinical trials; increase training and career development opportunities for minority scientists; build new and additional partnerships with minority institutions; increase representation of minorities on peer review groups; enhance recruitment

of underrepresented minorities to positions at the NIH; establish new partnerships with industry, foundations, and other Federal agencies (e.g., to hold town meetings); enhance dissemination of public information and outreach; and solicit advice and input from the extramural community (e.g., through NIH advisory councils).

Dr. Maddox noted that NIH's excitement about this plan and its renewed focus on health disparities has led to establishment of the NIH Center for Minority Health and Disparities, effective in FY 2001. The center will add to the efforts of the 10-year-old NIH Office of Research on Minority Health and will provide a coordinating focus for health disparities research at the NIH. Dr. Maddox noted that the concept of the center was generated and is well supported by the Congress. The center will have an expanded budget for research which will complement the separate programs already supported by the existing NIH institutes and centers.

Discussion

In response to questions, Dr. Maddox said that the NIH has recently developed new programs (e.g., the NIH Director's Award for Mentoring, the NIH Academy) to enhance recruitment and success of minority scientists at the NIH. She noted that Dr. Ricardo Martinez, Director of NIDCR's Division of Extramural Research, participates in a special NIH consultation group to address these issues. The Council congratulated the NIH on its plans and noted that similar plans are needed in the extramural community.

Dr. Maddox also noted that the NIH is addressing the ethical issues of research involving minority individuals and populations. The NIH is working closely with its Committee of Public Representatives to strengthen its community outreach and to broaden public input on these issues. To enhance NIH scientists' sensitivity to ethical and cultural issues for these populations, the NIH will be holding a trans-NIH training session for all extramural staff.

The Council expressed concern that the grouping of minority populations into several broad categories impedes understanding of the major differences within population groups (e.g., among the more than 500 Native American tribes, between Mexican Americans and Puerto Rican Americans) and may result in the accumulation of meaningless data, inappropriate interventions, and poor policies. The Council also urged that minority populations be involved in NIH's strategic planning for health disparities. Dr. Maddox said that the NIH is very sensitive to the complexity of the health, culture, and governing issues which distinguish different populations and intends to account for these in the strategic plan. She noted that the NIH solicited broad input from the public in developing the plan, as did other DHHS agencies, and has encouraged the public to comment on it. Dr. Kleinman commented that the related Healthy People 2010 process includes a major "grass-roots" effort and that Surgeon General David Satcher chairs this initiative as well as DHHS's strategic planning process for health disparities.

The Council noted that extramural programs targeted at the precollege level are needed to enhance the pipeline of minority scientists. Dr. Maddox said that the NIH's Office of Education has been working with elementary, middle, and high schools to develop science curricula that may stimulate students to consider a science career. Additional efforts are needed to interest parents and to educate the public about science and biomedical and behavioral research. In collaboration with the Student National Medical Association, the NIH recently held a very successful health fair at the NIH for minority students, which brought 500 students from the local area to the NIH campus. Dr. Maddox noted the need for a broader, organized, and focused effort beyond specific disease areas.

VII. STATUS OF MINORITY DENTAL APPLICANTS, STUDENTS, AND FACULTY

Dr. Jeanne C. Sinkford, Associate Executive Director for Equity and Diversity, American Dental Education Association (ADEA), Washington, D.C., reported on the status of minority dental applicants, students, and faculty. She noted that the ADEA changed its name (from the American Association of Dental Schools) to reflect all its constituents, which include the 55 U.S. dental schools, 10 Canadian schools, as well as

hospital, advanced, and allied health programs in dental education. The organization's four divisions remain the same: Government and Institutional Relations, Application and Student Services, Educational Policy and Research, and Equity and Diversity. Dr. Sinkford made available a packet of information from the ADEA, which included the Report of the ADEA President's Task Force on the Surgeon General's Report on Oral Health (September 10, 2000).

Dr. Sinkford noted that most U.S. dental schools are located in the eastern region of the country and relatively few are located in the West, except for California. Data for 1993-2000 show that the number of applicants to dental schools continues to decline from a peak in 1997, similar to declines in other health professions. This decline is particularly evident among Asians and Pacific Islanders and is also occurring among underrepresented minority groups (e.g., Black/African American and Native American/Alaska Native). The total number of applicants in 2000 was 6,735, a 21.7 percent decline since 1997 and an 11.2 percent decline from 1999.

First-year enrollment increased from 1970 to 1978, declined until 1990, and then increased again to 1997. In 2000, the total number of first-year students was 4,348. Dr. Sinkford noted that, during the 1990s, first-year enrollment for women was steady (at 36-38 percent), but first-year enrollment for Blacks/African Americans dropped consistently after 1995, from 252 to 189 students in 1999. The number rose slightly in 2000 to 200 Black first-year students. From 1995 to 1999, first-year enrollment for underrepresented groups (Blacks, Hispanics, and Native Americans) declined from 11.42 percent to 9.79 percent, rising slightly in 2000 to 10.26 percent. Dr. Sinkford noted that, although the percentage decline may seem small, the actual number of students is significant.

In 1999-2000, total enrollment in dental schools is 17,295. Dr. Sinkford noted that minority students account for about 34 percent of this number, but 24 percent of this group are not from underrepresented groups, as defined by DHHS. The percent of total enrollment for these groups is 4.68 percent for Blacks (n=810); 5.28 percent for Hispanics (n=913); and 0.57 percent for Native Americans (n=99). Dr. Sinkford also noted that students from these underrepresented groups are concentrated in relatively few schools. For example, 40 percent of Black dental students attend either Howard University or Meharry University.

The number of dental graduates each year from underrepresented minority groups has been consistent. The average number of graduates from 1984 through 2000 is 200 for Blacks/African Americans, 251 for Hispanics, and 13 for Native Americans. The number of students enrolled in advanced dental education programs totals 4,983 in 2000. From 1994 through 2000, the number of Blacks/African Americans enrolled in these programs has been relatively consistent and amounts to 233 (4.6 percent) in 2000; the number of Hispanics has been higher and amounts to 348 (6.9 percent) in 2000; and the number of Native Americans has almost doubled, to 15 (0.3 percent) in 2000.

Data from 1993 show that, of the 5,018 full-time faculty in dental schools in that year, 82.1 percent were Caucasian, 2.7 percent were Hispanic, 4.9 percent were Black, 5.8 percent were Asian, and 0.3 percent were Native American/Alaska Native. Dr. Sinkford noted that the 1998 data, which are being compiled, are similar and that these percentages for full-time faculty are very similar to the percent of enrolled students from these groups. Dr. Sinkford also noted that 290 full- and part-time faculty positions are vacant among 45 dental schools reporting in 1999. She suggested that, if all dental schools had reported, the number may be closer to 400. Most of the unfilled positions are in the clinical sciences (teaching, research, and patient care).

Commenting on the challenges ahead, Dr. Sinkford said that the ADEA is reviewing the effect of affirmative-action legislation on dental schools' ability to identify race as an admissions criteria. She noted that existing legislation affects 18 dental schools located in the states where challenges exist. Pending cases and those under appeal will affect another 12 dental schools. The ADEA is committed to its diversity objectives and is pursuing several "band-aid" approaches to address the systematic problems. Dentistry does not have a national minority student recruitment program. ADEA actions include: sponsorship of national minority recruitment and retention conferences; publication of a manual, Opportunities for Minorities in United States Dental Schools; partnerships and collaborative activities with the American Dental Association, other health professionals, and minority professional associations; and legislative

advocacy for minority programs. As a member of the Health Professionals for Diversity Coalition, the ADEA supports the following goal: "to ensure that health professions schools continue to have the freedom to consider race, ethnicity, and gender among many important factors in selecting those students who will best meet the country's health care needs in the years to come."

In closing, Dr. Sinkford noted that dentistry has the policies and commitment to make changes, but needs a concerted and organized effort with targets and goals for the next 5 to 10 years.

Discussion

The Council suggested that additional or differently compiled data would be informative. Members requested the following data: (a) the number of applicants, number of first-year enrollments, total number enrolled, and number of graduates compiled separately for each underrepresented minority group to show trends over time for each group; (b) schools' admissions criteria (e.g., test scores) correlated against students' success in completing dental school or entering a research career; (c) the rankings for underrepresented minority faculty; and (d) the distribution of minority faculty among dental schools, correlated with the distribution of minority dental students.

The Council emphasized the need to increase the number of minority faculty and researchers to accommodate NIH's strategy to expand minority participation in clinical research and clinical trials. Dr. Kleinman noted that the NIH has addressed this important issue in various recommendations and that additional resources and effective programs are needed. The Council commented on the relevance of this issue to existing training programs and noted the recent published information on disparities in promotion and tenure for underrepresented minorities in health professions schools.

VIII. HIGHLIGHTS OF NIDCR DISPARITIES ACTIVITIES

NIDCR staff presented an overview of NIDCR's research agenda for health disparities, special initiatives, and training activities. Additional information on these and other NIDCR efforts to reduce health disparities is available on the NIDCR home page [www.nidcr.nih.gov].

Overview of the Research Agenda

Dr. Kleinman summarized the "big picture" of oral health activities in 2000, which began in January with the release of the Healthy People 2010 objectives. Oral and dental health objectives have been an integral part of this activity since it began two decades ago. In March, Secretary Shalala launched the DHHS initiative in oral health, and the Surgeon General convened the Workshop on Children and Oral Health. This workshop was followed in May with the release of Oral Health in America: A Report of the Surgeon General and, in June, with the Surgeon General's Conference on the Face of a Child. Other activities included planning for several Federal-agency workshops on children and oral health; release of the first of two reports on the oral health of low-income populations, by the Government Accounting Office; release of a report on extending Medicare, including dental services, for certain conditions, by the Institute of Medicine; and oral health initiatives by the Health Resources and Services Administration (HRSA) and the Health Care Financing Administration (HCFA) (see section IX below).

Dr. Kleinman noted that, in early April, a draft of the NIDCR Strategic Plan to Reduce Health Disparities was provided for comment to the Council and oral health voluntary organizations. Subsequently, in late April, the plan was placed on the NIDCR home page, for public comment. This plan was developed through a "grass-roots" effort and presents three strategies, which are similar to those developed across the NIH: cross-cutting research initiatives, enhanced research capacity, and reaching the public. For each strategy, the NIDCR sets forth specific goals, objectives, and actions. For research to reduce health

disparities, the NIDCR plans to expand the current portfolio in two areas: oral infections (including dental caries and periodontal diseases) and neoplastic diseases. To enhance research capacity to address health disparities, the NIDCR plans to focus on training and career development and on community-based studies and clinical trials. To reach the public, the NIDCR plans to focus on health communications research and on integrating its information effort into broader NIH and DHHS programs.

Dr. Kleinman said that the NIDCR will be revising the draft plan based on the Council's discussion at the meeting and on other input received. The revised plan is expected to be completed in October 2000. She noted that the plan includes a suggestion to establish a Council subcommittee to provide oversight and identify outcome measures.

Special Initiatives

Dr. Norman S. Braveman, Associate Director for Clinical, Behavioral, and Health Promotion Research, NIDCR, summarized two NIDCR-led initiatives to reduce health disparities through research. He noted that these initiatives are continuing and are complemented by other extramural activities. Information on both initiatives is available on the NIDCR home page.

Centers for Research to Reduce Oral Health Disparities (CRROHD). This NIDCR initiative involves 10 other NIH components and Federal agencies, including HRSA. The concept for the centers was approved by Council in May 1999, the Request for Applications (RFAs) was issued in September 1999, and regional workshops to present the initiative were held in October and November 1999. In July 2000, the NIDCR received 23 letters of intent, and applications are due on November 15. Following a special Council review in August 2001, the NIDCR expects to make the earliest awards in August 2001. The NIDCR hopes to support up to five centers, for a total first-year cost of $1.5 million (depending on the availability of funds), and perhaps additional centers jointly supported with other partners in this initiative.

The objectives for the centers are to (a) support research leading to an understanding of the factors involved in health disparities in children and their caregivers, (b) support development, testing, and evaluation of interventions to reduce health disparities, and (c) serve as a training and mentoring resource. Dr. Braveman noted that, among all populations, children are most affected by health disparities and, for them, the implications of these disparities are greatest. Oral health care in children offers, perhaps, the first opportunity for caregivers and communities to affect individuals' lifelong health behaviors and health status. Dr. Braveman also noted that the NIDCR has broadened NIH's definition of populations that have disparities to include people who live in poverty, are medically compromised, or are culturally diverse (e.g., new immigrants who follow traditional health practices).

The centers will have three interactive components: research, training/careers/workforce, and community/intervention/service. They will be focused on research to reduce health disparities of children and their caregivers; involve inter- and intra-institutional networks and partnerships within academic health centers and with state and local health agencies and other institutions that serve these populations (e.g., community-based groups, foundations); emphasize multidisciplinary cooperation; and include evaluation of their impact on reducing or preventing health disparities. Dr. Braveman noted that this type of evaluation is a hallmark of the initiative and is unusual for the NIDCR and the NIH.

Each center will include an administrative core, at least four research projects, up to five short-term pilot projects each year, scientific cores, research and training networks, and training and career development. Potential areas of interest, based on the letters of intent, include the relationship between oral and systemic health and disease, the relationship between oral disease in mothers and early childhood diseases and growth and development, early childhood caries, epidemiological documentation of disparities in health and disease, risk factors for oral and systemic disease, and high-risk populations.

Discussion. The Council emphasized the need for flexible review criteria and for informed and mature reviewers who are knowledgeable about the social and behavioral sciences, about the populations to be studied, and about the issues in academia for minority researchers. Dr. Braveman noted that the RFA was intentionally designed to be broad in scope and inclusive and that the NIDCR has discussed this

flexibility with potential applicants and will address the issues with reviewers during a briefing session. Members also suggested that the NIDCR ensure a quality review by contacting potential reviewers by telephone, encouraging them to serve as reviewers, and emphasizing the importance of the review. Dr. Martinez noted that the NIDCR will be implementing such a strategy.

State Models of Oral Cancer. The NIDCR is collaborating with the National Cancer Institute to support this two-phase initiative to develop state models to reduce oral cancer through early detection and prevention. Dr. Braveman noted that state models are more more relevant than national models in this case because the issues and needs vary widely across the country. The initial phase of 3 years will include epidemiological assessment of oral cancer, assessment of the knowledge about oral cancer among health professionals and the public, documentation and assessment of diagnostic practices, and development of organizational infrastructures and plans of action. The second phase of 5 years is for development, implementation, and evaluation of interventions promoting awareness, prevention, and early detection of oral cancer.

Dr. Braveman noted that an informational conference about this initiative will be held on September 29; letters of intent are due December 15, 2000; and applications are due February 16, 2001. Following Council's review in June, the NIDCR expects to make the earliest awards in July 2001. The NIDCR anticipates being able to fund approximately 13 grants at $100,000 each in direct costs for each year.

Training Activities

Dr. James A. Lipton, Assistant Director, Office of Training and Career Development, Division of Extramural Research (DER), NIDCR, presented an overview of NIDCR's research training and career development activities related to health disparities. A major activity during the past 2 years was NIDCR's Blue Ribbon Panel on Research Training and Career Development to Meet Scientific Opportunities of the 21st Century, which was convened by Dr. Slavkin in July 1999 and co-chaired by Dr. Charles Bertolami and Dr. Joseph Martin. The panel's report, issued in January 2000, included a recommendation, or goal, to expand the diversity of the scientific workforce. The objectives related to this goal are to recruit and retain talented individuals from all the nation's population, to set specific goals to increase diversity in the workforce, and to evaluate the annual progress of this component of training and career development. Dr. Lipton noted that the NIDCR hopes to enlist a subgroup of the Council to advise on ways to evaluate progress.

Following up on the recommendations of the panel, the NIDCR recently issued a new National Research Service Award (NRSA) Institutional Research Training Grant (T32), as discussed with the Council previously. This new mechanism incorporates three previous NRSA programs which supported pre- and postdoctoral training, short-term training, and the institutional Dentist Scientist Award. Dr. Lipton noted that the T32 and other NIH training programs must have a comprehensive plan for recruiting and retaining underrepresented minorities, and applications for competing continuations (type 2 awards) must include a detailed report on these activities during the previous award period and provide followup on all individuals trained. He also noted that the tracking of individuals trained in research on health disparities is a key component of the new T32 and that the program allows for up to two additional positions to accommodate outstanding minority trainees if all approved positions are already filled. The NIDCR is one of the first NIH institutes to offer this provision.

The NIDCR Strategic Plan to Reduce Health Disparities highlights two other mechanisms which the Institute hopes to launch in 2001 or 2002: the Academic Career Award in Health Disparities Research (K07) and the Minority Mentored Research Scientist Development Award in Health Disparities (K01). Dr. Lipton noted that the K07 is utilized by other NIH components for curriculum development and that the K01 would support 3 to 5 years of additional postdoctoral training in a research-intensive institution.

Ms. Lorrayne Jackson, Diversity Programs Specialist and Co-Director, Diversity Programs, DER, elaborated on the range of NIDCR's activities in recent years. Successful programs initiated by the NIDCR include the Regional Research Centers of Minority Oral Health (RRCOMH), Research Supplements for Underrepresented Minorities, and Research Supplements for Individuals with Disabilities. NIDCR's

funding for supplements for underrepresented minorities at the high school, college, and graduate levels has increased in the past 2 years. Using the research supplements, the NIDCR is seeking to match students at various levels with NIDCR grantees, focusing on those in the NIDCR-supported Comprehensive Centers of Oral Health Discovery.

Last year, the NIDCR initiated a new outreach activity with the University of Puerto Rico (UPR) in placing UPR dental students in research environments with NIDCR scientists. Six students were placed with scientists at the University of Connecticut, New York University, University of California at Los Angeles, University of Minnesota, Tufts University, and Harvard University. For this past summer, approximately 20 students expressed interest in this program. NIDCR staff was successful in placing a total of 15 students at the following schools: 6 at New York University, 6 at Tufts/Boston University, 1 at the University of Minnesota, and 2 at the University of Rochester. Comments received from the extramural scientists and students have reflected an outstanding experience for everyone and the need to continue this program.

In collaboration with the National Institute of General Medical Sciences, the NIDCR also cofunds the Minority Access to Research Careers (MARC) and Minority Biomedical Research Support (MBRS) programs. The NIDCR has provided cofunds to a number of schools to support minority students' research and education experiences. Support of six students at the University of Texas, San Antonio, for example, has stimulated university faculty to serve on dental school committees and encouraged two students to consider entering dental school with an interest in a D.D.S./Ph.D. Under the MBRS program, NIDCR support is being used to develop continued excellence among biomedical research faculty at minority-serving institutions and to increase the interests, skills, and competitiveness of minority students and faculty in research.

In addition, the NIDCR cofunds two research career development awards through the National Center for Research Resource's General Clinical Research Center program: the Clinical Associate Physician Award and the Science Education Partnership Award. Both awards are available to minority investigators. In partnership with the National Institute of Neurology Diseases and Stroke, the NIDCR has sponsored a 1-week biotechnology course for faculty on recombinant DNA.

For 2001, the NIDCR plans to continue and expand all the above activities; to encourage the CCROHDs to apply for NIDCR support for training, including minority supplements; and to expand minority participation in the NRSA short-term training program.

Dr. Martinez noted that the NIDCR also will be collaborating with other NIH components in issuing a new RFA for planning grants to minority institutions to develop clinical research training programs for minority investigators. This program will have two phases, for planning and implementation. Dr. Martinez also noted that he co-chairs a Hispanic Task Force at the NIH, which was appointed by Dr. Kirschstein. This task force has made a number of recommendations to Dr. Kirschstein, which include recruitment trips to minority-serving institutions. Following on another recommendation from the task force, the NIH is convening a roundtable conference with organizations that are addressing minority health issues, on September 22-23.

Discussion

The Council noted that training programs should serve minority investigators at both minority and majority institutions. Council members shared their different experiences with attracting, recruiting, and accepting minority students interested in dental research. They expressed disappointment about the lack of significant change in the number of minority investigators in biomedical research, despite NIH's impressive training efforts, and called for more creative approaches. The Council emphasized the need for focused dialogue with institutions to address the barriers to recruiting and accepting students into biomedical research training programs, because the number of majority and minority students interested in biomedical research is increasing. For a future meeting, the Council requested a presentation on the NIH's undergraduate scholars program.

Dr. Tabak noted that the T32 program and a "one-student-at-a-time" approach have been effective in enhancing the pipeline of minority investigators. The Council applauded the NIDCR for its efforts to strengthen clinical research in minority health professions schools and urged the NIDCR to continue to explore ways to engage minority professionals in this field. To strengthen minority participation in clinical research and, more generally, in biomedical and behavioral research, specific attention is needed on a number of issues. The Council suggested that the NIDCR and the NIH could, for example, help ensure that institutions' recruitment plans are effective, foster mentors' personal involvement and commitment in recruiting and training students, facilitate objective reviews of student applications, develop effective leaders and leadership for changing the culture of academia, strengthen opportunities for high school students and develop mechanisms to foster science interest in grades K through 12, identify markers of success for training programs, and ensure the sufficient and continued support needed to "incubate" research. The Council noted that each of these suggestions could be converted into testable hypotheses for sociological and behavioral research that would yield important data for subsequent decisionmaking.

The Council noted that the NIDCR could take the lead at NIH to establish an "innovation fund" to support interesting and meritorious research that may not meet all the review criteria for centers and other initiatives. Staff suggested that the dental community could possibly designate contributions to this NIDCR fund through The Foundation for the National Institutes of Health, Inc. Dr. Lipton also noted that the research could be supported as an independent research project under the Scholar Development and Faculty Transition Award (K22).

Dr. Kleinman thanked the Council for its excellent comments and noted that Surgeon General Satcher has emphasized the need to improve access of minority students and investigators to research, training, and career development support.

IX. HEALTH RESOURCES AND SERVICES ADMINISTRATION HEALTH DISPARITIES PLAN

The HRSA plan for addressing health disparities was presented in two parts.

HRSA Health Disparities Plan

Dr. Felicia L. Collins, Clinical Coordinator, Office of Data Evaluation, Analysis, and Research, Bureau of Primary Health Care, HRSA, presented the agency's strategic direction for eliminating health disparities in the United States. Dr. Collins and Dr. Jeannine Willis are the co-leads of the HRSA Workgroup for the Elimination of Health Disparities.

Dr. Collins noted that the operating units of HRSA have a long history of implementing and supporting programs to improve the health status of vulnerable populations and that the new strategic direction was undertaken to establish an agency-wide framework for eliminating health disparities in these populations. HRSA's mission is "to improve the nation's health by assuring equal access to comprehensive, culturally competent, quality health care." Dr. Collins noted that HRSA's definition of access includes access to enabling services (e.g., interpretation, transportation), health education (to promote healthy behaviors and utilization of services), and support services (e.g., job training, Medicaid enrollment, housing assistance).

Overall, HRSA aims to increase access to health care for the 45 million Americans who are uninsured and the 48 million who do not have a primary health care provider. The main benefactors of HRSA's services are the populations known to experience health disparities: people of color, people with low income, people lacking health insurance, rural and urban residents, and children and elderly people. Dr. Collins noted that two-thirds of the users of HRSA-supported health centers and programs are people of color. Also, two-thirds of the users of centers have incomes at or below the Federal poverty line, and 85 percent have incomes 200 percent below this poverty line. Dr. Collins noted that HRSA's organizational structure and operating units are designed to serve all these populations and that every HRSA program or activity is related to the goal of eliminating health disparities.

In 1999, HRSA formally organized its strategic plan around the goal of achieving 100 percent access and 0 percent health disparities. Four long-range strategies were defined: eliminate barriers to care, eliminate health disparities, assure quality of care, and improve public health and health care systems. Recently, HRSA increased its focus on the second strategy and established the Workgroup for the Elimination of Health Disparities. HRSA's definition of health disparity is "a population-specific difference in the presence of disease, health outcomes, or access to health care." Dr. Collins reviewed each of the eight substrategies in HRSA's 5-year strategic direction for health disparities. She noted that, beginning in FY 2001, HRSA intends to increase its collaborations in this area and will establish an integrated agency-wide focus on the eight substrategies: (1) reduce the incidence/prevalence of disease and morbidity/mortality in targeted clinical areas; (2) increase health care utilization by underserved populations; (3) focus on target populations; (4) diversify the health care workforce; (5) increase the cultural competence of the health care workforce; (6) enhance and establish new partnerships; (7) translate knowledge into clinical practice; and (8) enhance data collection. Staff will be defining specific activities and developing implementation steps, drawing on the input of focus and advocacy groups.

Dr. Collins elaborated on substrategies 1 and 3, as especially relevant to NIDCR's research portfolio. The clinical areas under substrategy 1 include several related to NIDCR's programs: oral health, diabetes, HIV/AIDS, and cancer screening and management. For substrategy 3, HRSA's target populations will include racial/ethnic groups; underserved females and males; people with low income; rural and urban residents; residents of the U.S.-Mexico border; and gay, lesbian, bisexual, and transgender populations.

In closing, Dr. Collins shared data which showed an effect of HRSA-supported health centers in reducing African Americans' disparity for infant low birthweight. She noted that the challenge for HRSA in the future will be to document the effects of its programs more fully and to communicate its successes. She emphasized that dialogue and partnerships with the NIH, including the NIDCR, are critical to reaching HRSA's goal of 0 percent health disparities.

Oral Health Initiatives

Dr. Jim Sutherland, Oral Health Coordinator and Regional Dental Consultant for the West Central Cluster, HRSA, described the HRSA/HCFA Oral Health Initiative. The main themes, or goals, of this initiative are to eliminate disparities and barriers to care, respond to unmet needs for clinical services, increase the number of dental professionals, expand the dental public health infrastructure, restructure and increase coordination among Federal oral health programs, and coordinate Federal initiatives with key partners in the dental community. The initiative will be implemented through a central HRSA/HCFA coordinating team and regional teams in the 10 regions of the U.S. Public Health Service. Each regional team will be headed by HCFA and HRSA Regional Dental Coordinators and a representative from the Academy of Pediatric Dentistry.

The initiative includes three main types of activities: integrating activities within and between Federal agencies, partnering with stakeholders, and sharing scientific data. Dr. Sutherland noted that Federal staff and other stakeholders met jointly in 1998 to formally establish the initiative. Since then, the central and regional teams have been established and, in several HRSA regions, the initiative has been expanded to include Head Start and the Women, Infants, and Children program. Partnership programs to enhance children's access to dental services through Medicaid also have been established with various stakeholders, including national and state legislative groups, professional organizations, advocacy groups, and business groups. To share scientific data, HRSA/HCFA are seeking collaborations to compile information from existing databases (e.g., the National Health and Nutrition Examination Survey, Healthy People), prepare this information for distribution at local levels, and to disseminate new surveys and reports on oral health (e.g., the recent Surgeon General's report on oral health) locally.

Dr. Sutherland emphasized that the initiative involves collaboration at the national level to effect change at the local level. He noted that, at the national level, oral health is now a DHHS initiative supported by Secretary Shalala. The department's initiative includes four specific sets of activities: general advocacy, the Secretary's Oral Health Leadership Meeting, the Secretary's Work Group on Oral Health, and the Federal Partnership Workshop on Children and Oral Health. Dr. Sutherland also noted a number of other Federal

(national) activities in oral health, which include two reports from the Government Accounting Office, on dental disease as a chronic problem for vulnerable populations and on factors affecting use of dental services; a listserv, "KidsOralHealth," for state Medicaid and dental directors and the HRSA/HCFA teams; a National Maternal and Child Oral Health Resource Center [www.ncemch.org/oral health]; the HRSA oral health web site [www.hrsa.gov.oralhealth]; the NIDCR's CRROHDs, which HRSA strongly supports with other partners; the Medicaid Maternal and Child Health Technical Advisory Group; a National Health Service Corps Scholarship Program, Dental Initiative Pilot; HCFA's licensing agreement with the American Dental Association (ADA) to use ADA codes for Medicaid; an Oral Health Initiative Medicaid "toolbox" of useful actuarial and other information for states; and four centers for health workforce studies.

Two projects with special potential for building capacity in oral health at the state level involve use of Geographic Information System (GIS) mapping. GIS technology is being used for (a) a national, Internet-based initiative to collect data on the public health infrastructure and demographics of each state and to train state directors in the technology to use these data, and (b) state-wide assessments of dental services, access, utilization, and infrastructure at county and sub-county levels. Dr. Sutherland listed other regional and state activities in the Oral Health Initiative, which include state dental summits and workshops; representation on Federal advisory groups; participation in regional activities of national programs; regular conference calls with state dental directors; participation in onsite reviews of state programs; solicitation of Federal funds for dental programs; recruitment of dental consultants; and followup on state dental summits.

Future objectives for the HRSA/HCFA initiative include the following: expand funding for dental programs in the community health centers, increase the number of grants for sealant programs, expand the number of loans and scholarships for dental students willing to practice in underserved areas, support development of state infrastructures, provide GIS mapping for all states, simplify the designations for Health Professional Shortage Areas, and change Federal policies that restrict provider enrollment and access to care. In closing, Dr. Sutherland noted that the CRROHDs, the national oral health surveillance system, and the national oral health plan offer opportunities for partnership.

Discussion

NIDCR staff thanked Drs. Collins and Sutherland for their presentation of Federal collaboration and coordination in oral health, noting that two additional key partners are the Centers for Disease Control and Prevention and the Indian Health Service. Dr. Sutherland agreed that the potential for collaboration with these agencies is high and that more collaboration is needed.
The Council complimented the NIDCR on formulating an agenda for the meeting that highlights potential collaboration and leveraging with other Federal agencies. The Council encouraged HRSA and the NIH to inform the academic community (e.g., dental school deans) and dental professional associations (e.g., the ADA, ADEA) about activities at the national, state, and local levels and to involve them in these activities. A participant noted that the insufficient Medicaid reimbursement to dental providers contributes significantly to health disparities by barring access to affordable care. Dr. Collins noted that an increasing portion of HRSA's budget is needed to cover uncompensated care and that the number of uninsured Americans is increasing by 1 million each year.

X. DHHS OFFICE OF HEALTH PROMOTION AND DISEASE PREVENTION AND THE HEALTHY PEOPLE 2010 INITIATIVE

Dr. Randy Wykoff, Deputy Assistant Secretary for Health for Disease Prevention and Health Promotion, DHHS, presented an overview of Healthy People 2010, including the Leading Health Indicators, and possible ways to maximize this initiative. Healthy People 2010 is coordinated by the DHHS Office for Disease Prevention and Health Promotion.

Dr. Wykoff noted that Healthy People 2010 is a comprehensive set of national 10-year objectives that are developed through a collaborative process involving both the public and private sectors. All the objectives are specific and measurable over time based on data. The document, published and distributed by the Federal Government, also is a statistical description of the health status of Americans, including racial and

ethnic disparities; a textbook on current public health priorities; and an important part of the national strategic plan for improving health. Healthy People 2010 is the third iteration of an effort that began in 1979 with publication of the Surgeon General's Report on Health Promotion and Disease Prevention. Ever larger and more complex, this iteration has two overarching goals, 28 focus areas, 467 objectives, and 10 leading health indicators.

Dr. Wykoff noted that the two goals for Healthy People 2010 are to increase understanding and years of healthy life and to eliminate health disparities. The 28 focus areas, which include oral health, are addressed in separate chapters, and each chapter sets forth 6 to 25 measurable objectives. Dr. Wykoff noted that the oral health chapter sets forth 17 specific objectives and that additional related objectives are included in other chapters (e.g., on cancer, health professions). For health disparities, national rates and measurable objectives are presented for each of DHHS's racial and ethnic categories. Data also are presented for gender, education, economic, and geographic differences.

For the first time, the document includes 10 Leading Health Indicators in order to communicate information on the public's health in a more accessible and captivating way. The indicators are: physical activity, overweight and obesity, tobacco use, substance use, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access. Dr. Wykoff noted that although oral health is not an indicator *per se*, it is clearly included in several indicators. Dr. Wykoff noted that Healthy People 2010 is a tremendous national resource and a remarkable investment. He encouraged the Council members to utilize the document to its fullest potential. He suggested that, to take full advantage of its potential to influence public health over the next 10 years, the NIDCR and the Council could use the document to access the most current data on health statistics; address and promote issues (e.g., water fluoridation) with the public, media, and elected officials; define the basis and provide a common template for forming coalitions and partnerships with community-based organizations; and provide the basis for agreements and interactions within and with government. Like a battery filled with energy, the challenge is to use it effectively in a systematic way.

In closing, Dr. Wykoff noted that the final version of Healthy People 2010 is to be released on November 11, 2000, and that it can be obtained from the Government Printing Office or from DHHS' web site for this initiative [www.healthypeople.gov]. He invited comments and suggestions.

Discussion

Dr. Wykoff commented that states will be developing their own Healthy People plans and that the dental community will want to be involved in this process to ensure that oral health is represented. He noted that DHHS is exploring development of a mechanism to help states communicate with each other on this initiative.

XI. BREAKOUT GROUPS

Dr. Kleinman asked the Council members, other attendees, and staff to divide themselves into three breakout groups to focus on the NIDCR Strategic Plan to Reduce Health Disparities and to address the question, "What else can we do to address health disparities?" She charged the groups to consider four specific questions: (a) What specific opportunities can your group identify for implementing the plan? (b) What are the strengths and weaknesses of the plan, and what changes would you make to the plan? (c) How can we better disseminate the plan and stimulate and expand interest in its implementation? (d) What suggestions do you have for leveraging efforts involving NIDCR's plan and those of other organizations or agencies? Dr. Kleinman also invited the Council to establish a subcommittee to provide critical oversight for the plan and to be responsible for setting targets and assessing progress.

The breakout groups met separately for approximately 45 minutes and reported their results to the full Council in plenary session. The groups were chaired by Drs. John Alderete, Dominick De Paola, and Joan Reede. The reports from the breakout groups are summarized below under three topics, reflecting their

reports: revisions to the plan, implementation and dissemination of the plan, and leveraging NIDCR's efforts.

Revisions to the Plan

The breakout groups noted that having a strategic plan to reduce health disparities was a strength in itself and that the focus on health disparities gives the NIDCR an opportunity to pursue substantive issues in oral health services research which are not being addressed or are inadequately addressed by other agencies and which provide the critical underpinning for the basic science component of dental, oral, and craniofacial research. Suggested modifications for the three emphases in the plan are grouped below.

Research Initiatives. For this section, the groups recommended that the NIDCR add an explicit health services component to address access, prevention, outcomes, and cost-effectiveness data, and the personnel needed for service delivery; adopt a more integrated model of health (e.g., the OBSSR model) that encompasses genetics, behavior, and environment and includes nutrition and health promotion and disease prevention; give more emphasis to reducing health disparities, in the short and long term, than to acquisition of data; give more attention to behavioral research and issues; specify the mechanisms for achieving the desired outcomes; and include assessment of the implementation and effectiveness of programs and interventions to address health disparities.

The groups also suggested that the NIDCR consider the status of its research on the oral health of ethnic and underrepresented minorities, the effectiveness of translating research results to dental health and treatment programs for these groups, and the adequacy of NIDCR procedures for equitable recruitment and retention of minorities in clinical trials. The groups urged that research applicants be required to specify the anticipated effects of their research on social or health disparities, provide data to support the efficacy of the proposed research, and indicate the potential for generalizing findings across a community or population group. They also encouraged NIDCR to assure that the proposed CRROHDs have realistic expectations and outcomes.

Research Capacity. For this section, the groups recommended that the NIDCR emphasize the need for improved training in health disparities; urge research training programs to expand include issues related to health disparities and partnerships with other agencies with similar interests in multidisciplinary health services research; note the importance of respect for, and cognizance of, the culture of underrepresented minorities in research training; encourage development of more ethically and culturally sensitive research training programs to enhance recruitment of clinical researchers from minority populations; encourage the dental professions to "buy into" a new concept of training focused on minorities and health disparities; highlight requirements to include issues related to health disparities (e.g., cultural competence) in research training curricula; address leadership training for research faculty, administrators, and policymakers, and include dissemination of information on research that is needed and the resources available to support this research; address the role of minority scientists in the decisionmaking and research-prioritization processes; and be more explicit about mentoring and expanding partnerships (e.g., with NIH's Office of Science Education).

The groups also suggested that the NIDCR consider expanding the research and training base by identifying creative and innovative ways to attract and involve organizations and institutions that are conducting quality research on health disparities but do not have NIH funding; and establish consequences for research training programs that do not fulfill stated goals for minority recruitment and retention.

The groups suggested further that the NIDCR be more explicit about supporting K-12 science and health education; note creation of a mechanism to assist teachers and/or fund development of teacher-to-teacher programs to advance K-12 science and health education; indicate plans to collaborate with other NIH components on networks already established with teachers; include networking with parents and other social supports; and address transgovernment interactions in K-12 education and collaboration with community-based organizations. The groups encouraged the NIDCR to review successful models of

research funding for K-12 teachers and students and to advertise support for training initiatives at the precollege and K-12 level.

Public Outreach. The groups recommended that the NIDCR promote public involvement in the strategic planning process and ownership of the strategic plan.

Implementation and Dissemination of the Plan

To ensure effective implementation and dissemination of the plan, the breakout groups recommended that the NIDCR create a partnership of organizations (e.g., dental associations, dental industry, Oral Health America, Research! America, patient advocacy groups, managed care organizations) to communicate that prevention is cost-effective and NIDCR's research programs can reduce oral health disparities; accompany this partnership with a marketing campaign to educate health professionals and consumers that "oral health matters" and promote this "message" in editorials in dental, medical, and allied health journals; and consider using R25 education grants to implement these approaches.

Leveraging NIDCR's Efforts

The breakout groups suggested that the NIDCR link up with diversity programs in universities to leverage funds and activities; interest foundations in issues related to health disparities and, specifically, oral health disparities; network with education and health professional associations to leverage support and advocacy for oral health issues; and inform dental industry about these activities and encourage them to "buy into" the process.

XII. NIDCR INTERNATIONAL ACTIVITIES

Dr. Lois K. Cohen, Associate Director for International Health, NIDCR, presented an overview of NIDCR's international activities. The NIDCR Annual Report of International Activities, FY 1999, was distributed to the Council.

Dr. Cohen emphasized that science has no boundaries and that solving global health problems requires collaborative, collegial research. In 1998, the NIDCR established a separate Office of International Health to coordinate and facilitate the Institute's international activities. The office has developed a global strategy and a flexible research agenda driven by science questions that need to be addressed internationally. The areas of focus are birth defects (e.g., craniofacial anomalies), micronutrient deficiencies (e.g., fluoride), infectious diseases (e.g., noma), head and neck cancer, biodiversity and oral therapeutics, and quality of life and health promotion.

Dr. Cohen noted that international activities account for slightly more than 2 percent of the Institute's budget (similar to the NIH average) and that most of the expenditures support foreign scientists within the Division of Intramural Research (DIR). The NIDCR also supports foreign research grants, foreign components of domestic grants, foreign contracts, and international travel. In FY 1999, the NIDCR provided support for about 90 foreign scientists in DIR who represented 29 countries; about 35 percent came from China and Japan. Within DER, the NIDCR supported nine foreign grants, 22 domestic grants with a foreign component, and 1 contract. Dr. Cohen noted that these efforts are important for building capacity here and abroad to answer important scientific questions.

A major initiative for the NIDCR in FY 1999 was the development of an International Collaborative Oral Health Research (ICOHR) planning grant mechanism. Dr. Cohen noted that the Council had approved the concept of this grant and that the NIDCR has awarded six grants for planning international collaborative research in the following areas: oral infections and vascular risk, oral cancer, measuring child oral-health-related quality of life, temporomandibular joint (TMJ) disorders, models of health inequalities of childhood dental caries, and genetic epidemiology of oral clefts. Dr. Cohen noted that Council member Dr. Samuel Dworkin is the principal investigator for the grant on TMJ disorders. The NIDCR also partners with the NIH's Fogarty International Center to support training in oral health research on HIV/AIDS and emerging infectious diseases.

In addition to these research efforts, the Institute collaborates with international and multinational organizations to leverage oral health activities and associated resources. NIDCR's international collaborative research agenda, for example, derives from an earlier international effort to identify priority areas for research. That effort represented a collaboration among the NIDCR, the International Association for Dental Research, the World Health Organization (WHO), research scientists from the G-7 countries, and others from developing nations and the emerging-market economies. And, recently, the NIDCR was redesignated as a WHO Collaborating Center for International Collaboration in Dental and Craniofacial Research. The Institute has been a WHO collaborating center since the 1980s, when the concept of WHO collaborating centers was established. Since then, the NIDCR has fostered networking among all WHO collaborating centers in oral health, as well as WHO collaborating centers for health in this hemisphere.

In closing, Dr. Cohen thanked the Council for its support in establishing the Office of International Health and invited its continued input on the Institute's international activities.

CLOSED PORTION OF THE MEETING

This portion of the meeting was closed to the public in accordance with the determination that it was concerned with matters exempt from mandatory disclosure under Sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2).

There was a discussion of procedures and policies regarding voting and confidentiality of application materials, committee discussions, and recommendations. Members absented themselves from the meeting during discussion of and voting on applications from their own institutions, or other applications in which there was a potential conflict of interest, real or apparent. Members were asked to sign a statement to this effect.

XIII. REVIEW OF APPLICATIONS

Grant Review

The Council considered 327 applications requesting $70,492,343 in total costs. The Council recommended 238 applications for a total cost of $31,211,337 (see Attachment II).

ADJOURNMENT

The meeting was adjourned at 12:30 p.m. on September 22, 2000.

CERTIFICATION

I hereby certify that the foregoing minutes are accurate and complete.

_____

Dr. Lawrence A. Tabak
Chairperson
National Advisory Dental and
Craniofacial Research Council

_____

Dr. Dushanka V. Kleinman
Executive Secretary
National Advisory Dental and
Craniofacial Research Council

ATTACHMENTS

I. Roster of Council Members
II. Table of Council Actions
III. Director's Report to the NADCRC, September 2000

NOTE: A complete set of open-portion handouts are available from the Executive Secretary.